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# Women's Concerns Report


In this issue Anne Chamberlain and Emily Sippel share their personal struggles with mental illness. Another woman speaks anonymously about her experience as the mother of a child with a serious mental disorder. These women tell of both positive and negative reactions from their church communities. Karen Jantzi addresses practical ways we can respond to the needs of ill individuals and their families in our congregations.

There is a growing consumer movement, made up of mentally ill people and their families, demanding from society more appropriate responses to their needs. Information and assistance is available in Canada from the Canadian Mental Health Association and in the United States from the National Alliance for the Mentally Ill. More information on these and other resources is listed in this issue.—*Jan Engle Lewis.*

**Jan Engle Lewis, a psychiatric nurse specialist, is a member of the MCC Committee on Women's Concerns representing the Brethren in Christ Church. She lives with her husband and son in Alexandria, Va.**

# Mental Illness

This *Report* focuses on serious mental illness—biochemical diseases of the brain, usually involving a genetic factor. This group of illnesses includes schizophrenia, bipolar (manic-depressive) disorder and clinical depression. These diseases, like diabetes or high blood pressure, can often be effectively treated with medication, though not permanently cured.

In spite of advances in understanding the causes and treatment of mental disorders, many of us feel fearful and helpless when faced with mental illness in ourselves or in a family member, friend or acquaintance. These responses, along with continued ignorance about mental illness in the general populace, tend to perpetuate the stigma and isolation which so many ill individuals and their families experience. The church community can play a key role in providing on-going support for those faced with these often devastating illnesses.

One in four families in North America is touched by serious mental illness, so most of us have had or will have occasion to be challenged in some way by this problem.

**by Emily Sippel**

# Coping with Mental Illness

I grew up in a Quaker home and became a Mennonite after my marriage. Negative emotions were unacceptable in my family. I think I got a double dose of disapproval because females are not supposed to experience "negative" emotions, like anger. By the time I was a teenager I was exploding with rage. I was angry at injustices that had been done against me by the family. Years later, after much pain, my doctor would say "there is evidence in your family life that you suffered deprivation." He repeated the word deprivation to emphasize his point.

**One out of six hospital beds in the U.S. is occupied by a mental patient.—*What Everyone Should Know About Mental Health.***

**One in four families is touched by severe mental illness.**

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I couldn't believe that a God who was loving would permit such injustices to occur. In 1973, when I was 21, the anger, repressed so much during my teenage years, erupted and I found myself a patient in the psychiatric ward.

I was a model patient. I attended therapy sessions and took my medicine. In 1974 I returned to college and completed my degree. In 1975 the doctor took me off the medication.

After a year I felt myself slipping down the path to insanity. When I started to hallucinate I went back to the doctor. I had no idea at that time that these illnesses were chronic. I was devastated. In therapy I received little help when I was so upset to learn that the illness was long-term. I couldn't cope with the knowledge that it was chronic; I retreated into a fantasy world. Fantasy didn't hurt. When I read a book or watched a film I escaped the pain of everyday life. Eventually the line between fantasy and reality grew dim and the world of the imagination claimed me.

It is not a good idea for a fantasy lady to marry a real human being. But that is what I did and it was too much for me. I couldn't cope with the realities of marriage—real bills, a real person with his own demands. Once again I ended up in the psychiatric ward of a private hospital. To my surprise I received excellent care.

My husband and I were living on a shoestring and when I was released from the private hospital I went to a state facility for my treatment because it was what we could afford. I have never in my life endured such incompetence. I am sure this institution was pressured because they had too many patients but they were also sloppy and careless. For instance, no lithium blood levels were done during the six months I was a patient there (lithium is used in the treatment of bipolar disorder) and these must be done at regular intervals because the medication can become toxic in the bloodstream.

I received no counseling in the two months following my release from the hospital. If I had wanted to hurt myself I had two months of opportunity to do it. Finally, the doctor neglected to read my chart and refused to see me to renew my medication.

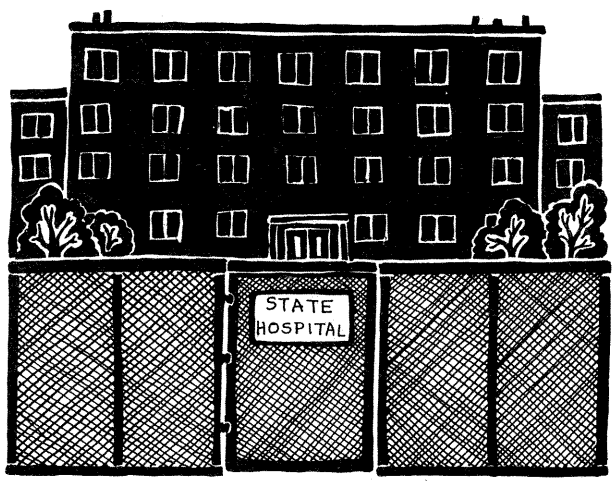
During this time I endured mounting frustration and finally talked to a member of the Franconia Conference Task Force on Mental Illness of the Mennonite Church. The psychiatric nurse who interviewed me helped me think of what steps I could take since the state system had failed me.

I appealed to the doctors at the private hospital where I had been a patient. I phoned the doctor and explained the situation and I followed up the phone call in writing. Finally, in desperation, I phoned the head of the hospital who asked,"Emily, are you too smart for this program?" For years I had heard "sick, sick, sick", but no one had ever said "smart". Ultimately, I was able to go back to that hospital and get the treatment I needed.

By then my poor husband had been through the ringer. In the end, we had to get counseling for him which the Mennonite church helped us pay for.

I learned some things through this experience. Growing up in a pacifist home, I needed to be taught that pacifist does not mean passive. It was only after I was willing to act that I could take positive responsibility for my experience. For example, during the time I was experiencing little support from the state system I was attending Weight Watchers classes and getting much support in an area that helped my health. I'm proud to say I was successful and lost over 50 pounds with that program.

I also learned that there are caring people in the Mennonite church who intervened when the people who should have cared (my family or the state system) were out to lunch. This is often the role of the church—to care when others are careless and to enable a person to grow.



- **Mennonite Health Services phychiatric centers, sponsored by constituent churches through MCC:**

- **Brook Lane Psychiatric Center P. O. Box 1945 Hagerstown, MD 21742 1945 Tel. (301) 733-0330**

- **Oaklawn Hospital P. O. Box 809 Goshen, IN 46526-0809 Tel. (219) 533-1234**

- **Penn Foundation for Mental Health 807 Lawn Ave. Sellersville, PA 18960 Tel. (215) 257-6551**

- **Philhaven Hospital P.O. Box 550, 283 S. Butler Rd. Mt. Gretna, PA 17064 Tel. (717) 273-8871**

- **Prairie View P. O. Box 467 Newton, KS 67114 Tel. (316) 283-2400**

- **Eden Mental Health Centre P. O. Box 1300 Winkler, MB R6W 4B3 Tel. (204) 325-4325**

- **Kern View Hospital 3600 San Dimas Bakersfield, CA 93301 Tel. (805) 327-7621**

- **Kings View 1470 W. Herndon Ave. Fresno, CA 93711 Tel. (209) 432-1900**

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Finally, I learned that it's important that family members learn to affirm one another. There was very little affirmation in my home life. It was shadowed by doubt and suspicion. I hated myself pathologically. I needed to hear something positive about me from someone else. When I was in the hospital Dr. Leonard affirmed me by saying, "You're strong." Later Dr. Delaplane affirmed my by asking "Emily, are you too smart?"

My mind is broken but I don't think my spirit ever was. Sometimes I've had to live only on my spirit; my mind and body were too fractured. I am very thankful to God for grace in my life, for God's love and for the gift of the many caring people who are part of my world.

**Emily Sippel is a member of Ambler Mennonite Church. She lives with her husband, Peter, in Doylestown, Pa.**

**by "Anonymous" with Jan Lewis**

# On Having a Son with Serious Mental Illness

*"Anonymous" is a Canadian Mennonite woman who wants to share her story, but does not yet feel prepared to deal with the possible reactions of her church and family. Following are some of her thoughts and feelings about having a son (now college age) with a serious mental illness, bipolar (manic-depressive) disorder. Her expressions have been paraphrased based on notes from a recent telephone interview.*

We've experienced a range of emotions—shock at first, a sense of being stigmatized, guilt, anger at the reactions of others, and anger at God. Our daughter is afraid she will get the disease, and wonders about her own children.

We feel anguish during the bad times. It's as though our son dies every two years, sometimes for six months, and then comes back to life. (Bipolar disorder is cyclical in nature.) Sometimes one wishes that person (the ill one) would die. This brings more guilt.

People at church seemed embarrassed, and not really responsive—like they didn't care. But maybe they just didn't know how to react. Some thought we just needed to pray harder. Church was not the place I wanted to be.

Some wonder what they can do for you, but you don't know what to say—you're just barely coping yourself. Others bring food and that is helpful. Sometimes when people come to visit we don't know what to say; we have at times just sat there like zombies.

Our son is at university and doing OK right now and is stable on medication. We hope he will be able to help others. As for the future, and understanding the illness and how to cope with it, we're awaiting further light.

**The brain is a major organ of the body. It, too, can become ill.**

- **How can I tell if someone is mentally ill? Often it's not easy. A person usually becomes ill slowly. Be alert for symptoms such as—**
- **silent, listless behavior.**
- **suspicion without cause (paranoia).**
- **anxiety over imagined problems.**
- **sudden changes in mood.**
- **poor work performance.**
- **hallucinations.**
- **physical ailments.**

**A single symptom or isolated event isn't necessarily a sign of mental illness. But a continuing pattern of unusual or extreme behavior may mean help is needed.—*What You Should Know about Mental Illness in the Family.***

**by Karen Jantzi**

# Responding to the Needs of People with Mental Illness

"We'd like to help but we don't know what to do. After all, we're not psychiatrists. We might do more harm than good. Besides, he won't listen to any of our advice. And sometimes when we're trying to be friendly, he yells or curses at us. He just doesn't seem to want our help."

"Well, you know, if she would just make peace with God, then this depression thing would stop. I've told her I'd pray with her and I did. But it didn't help. I guess she must have some unconfessed sin or maybe she just doesn't believe."

"You know, we had a prayer meeting for her after she was admitted to the hospital. She was acting real crazy. We prayed that the demons would be released. After she was discharged, we had another service, laid hands on her, cast out the demons. Didn't seem to help much. I guess she isn't ready to be freed."

"The congregation was real supportive when I broke my leg. But now that my son has been diagnosed as having schizophrenia, no one seems to want to talk to me. I feel alone, like a leper. I guess the church really doesn't care."

Have you heard any of these statements in connection with someone who has a chronic mental illness? In my experience, they are all too common. How do you respond to the person who is always in need? What do you say when nothing you say seems to make any difference? What do the person with a mental illness and their family need from a congregation? John Timmerman in *A Season of Suffering* says it best: "...the family in need needs others to enter into their need with them. When the music is all broken, the harmonies distorted and the tune lost, we need others to enter in to show the way back to rejoicing."

It's commonly believed that it is the responsibility of the pastor to deal with "those kinds of problems". There are few pastors who have the time and energy to effectively minister to everyone who is needy. We all lead busy lives but we must take time to care for each other. The biblical concept of jubilee was based on the people of God working actively at justice, mercy and restoration. This was not a commandment for the priests but for all the people of Israel. The parable of the good Samaritan was given to each of us, not just to our pastors.

The first step in responding effectively to persons with mental illness is to learn as much as you can about it. Talking with people who have a mental illness will give them a chance to teach you about the struggles they face. Explain why you are interested and that you want to learn from their experiences. Be prepared to listen without offering advice or suggestions.

Prayer is sometimes difficult or even impossible when someone is in pain. It is during those times that we can assure others we are praying for them. Don't limit your prayers to asking for healing. Pray for strength, ability to make decisions, peace and a sense of God's presence. Let the persons know that you will be praying for them at a certain time every day. Ask permission to share their needs with others who will also commit themselves to regular intercession.

Provide support through congregational small groups. There are several models of structured groups that are trained to respond to mental and emotional problems.

**• Facts about recovered mental patients:**
**• mental illness is often temporary in nature.**
**• following mental illness, social rehabilitation is usually needed.**
**• some are impulsive and their actions unpredictable when they are actively ill. But once they have recovered, most of them are consistent in their behavior and are likely to present few surprises to those who know them.**
**• persons with schizophrenia do not really have split personalities. Rather, when they are ill, their thinking becomes confused.**
**• patients who have come through mental illness and have returned to the community rarely present a danger to the public.**
**• mental patients are more likely to be depressed and withdrawn than wild and aggressive.**
**• shock treatment is an effective way of dealing with certain cases of serious depression that are resistant to drugs and "talk" therapy.**
**• most recovered mental patients are rational and intelligent.**
**—Excerpted from *The 14 Worst Myths About Recovered Mental Patients.***

Gather together everyone who is already involved with the person and make a specific, goal-directed plan of care. Recently, I was contacted by a pastor who was frustrated with the amount of time and energy being put into a family situation. While the congregation wanted to help, they often felt that they were going in circles. I met with the pastor and ten others who were relating to the family. We discussed the ways they were helping and how they felt about the responses they were getting. Some of them expressed frustrations at seeing no changes. Others expressed fear that they were doing more harm than good. By the end of the evening, there was agreement that this group wanted to continue working with the family.

We met a second time to focus on specific ways they could help. I spent part of the time helping them understand mental illness, the causes, effective ways of helping and the need for deciding how much time and energy they were willing to give. We identified the areas that the group wanted to focus on, discussed what had been helpful in the past, what had not worked and what the group was willing to try in the future. This led to the development of specific supportive roles that each member of the group would carry out. It was interesting to note that by the end of the evening, members of the group began to share their own insecurities and need for affirmation. We put in place a support network for the group members as well as the family.

Many people are afraid of mental illness. They aren't sure what to say or do and so do nothing. This only increases the isolation and pain that families and individuals feel. There is a mistaken notion that you have to be a professional to know how to relate to people correctly. While it is true that certain aspects of care should be handled by people who have been trained, there is much that everyone can do. A friendship should not provide "therapy." A friend is someone who will listen, laugh, cry and maybe even get angry with you. Sharing in the every day life and activities of a person is ministering healing.

People are often afraid that once they become involved they will be overwhelmed by the needs. This does not have to happen. I encourage people to be aware of their time, energy and patience limitations when they commit to doing things for or with someone. It is acceptable to say "No, I'm not able to do that." If someone calls to talk with you and you only have ten minutes to talk with them, tell them that and stop the conversation after that time. You do not have to feel guilty for admitting to limitations if you do so in a gentle but firm manner. There may be times when the person will become angry with you. Accept this, acknowledge the anger, but don't back down. "I'm sorry that you're upset, but this is what I must do" is a legitimate reply. If you are able, you could offer an alternative to the refused activity. "I can't talk with you now but can I call you back in an hour?" "I'm busy right now but we could have lunch on Tuesday."

I believe that caring takes planning, commitment and willingness to be open and honest. It is only when we are willing to take these risks that we can bring harmony, jubilee to the lives of those who are ill.

**Karen Jantzi lives in Schwenksville, Pa. and is a member of the Salford Mennonite Church. She is a mental health advocate for Franconia Mennonite Conference working with pastors and congregations, educating and resourcing on issues related to chronic mental illness. She is project director for a board developing long-term housing for persons with chronic mental illness and does private work with congregations teaching them how to be supportive of persons who have ongoing problems.**

**"Depression" is just a word until it becomes a reality in your *family.—Living with a Depressed Person.***

## A Prayer

O God, You care about the suffering of your children. Grant us the gifts of understanding and acceptance that we might reach out in love to those struggling with serious mental illness and to their families. Strengthen and encourage those who suffer not only from mental illness but also from the stigmatizing attitudes of the uninformed and uncaring. Help us, as Your Body, to witness to Your love and grace by the manner in which we care for one another. AMEN.—*Who Are the Mentally Ill?*

## Women Suffer Twice As Much Depression

Women are twice as likely as men to experience depression, but a task force of the American Psychological Association said the reason for this difference is not just biology.

Patterns of thinking, physical and sexual abuse, poverty and unhappy marriages are all woven into a complex tapestry that puts women at double the risk for depression, said a report released by the APA.

A three-year study by a committee of experts organized by the APA found that at least seven million American women suffer from depression and that most will go untreated, often with "tragic, unnecessary losses" such as suicide.

"Women truly are more depressed than men primarily due to their experience of being female in our contemporary culture," said Ellen McGrath, chairwoman of the National Task Force on Women and Depression.

McGrath said the task force found that women of all races, ages and income levels—in Europe, Africa and North America—are all at higher risk than men for most types of depression. And, said McGrath, the reason is not that women are more apt to admit their feelings.

"It is astonishing how often this difference is denied by assuming that women more readily report emotional distress than men," she said. "This argument says women are not really more depressed, they just say and think so."

The report by the task force said a number of social, economic, biological and emotional factors raise the risk of depression for women. Consequently, the experts said, women and their depression should be studied in a "biopsychosocial context" that recognizes the varied effects of gender differences in all these factors.

Among the task force findings:

> Biology is not as strong an influence in women's depression as previously believed. Menstruation, pregnancy, abortion and menopause are not major factors in significant depression for most women. Infertility is, however, with up to 40 percent of women studied saying the inability to conceive is "the most upsetting experience of their lives."
>
> Depression in women may be related to gender-related personality styles that include passive, dependent patterns and negative thinking, but this requires more research. "The research suggests women focus too much on discussing depressed feelings instead of developing action and mastery strategies," McGrath said.

Abuse early in life may play a large role. The study said that between 37 percent and half of all women have had "a significant experience of physical or sexual abuse before the age of 21." For many women, depression may

**The church has not always been an exemplar in the treatment of mentally ill people. Our predecessors may have believed that God caused mental illness for punishment, by withdrawing the Spirit or sending an evil spirit to invade a person. Later religious authorities themselves punished and/or killed mentally ill people after labeling them heretics or witches. People with mental illness were locked away, denied meaningful relationships or occupations, and institutionalized for life.—*Chronic Mental Illness: A Congregational Challenge.***

be the result of post-traumatic stress syndrome or even undiagnosed head trauma from battering.

Unhappy marriages and parenthood are important factors. The study said women are three times more likely than men to be depressed in unhappy marriages, and that having young children around creates a vulnerability to depression. "The more children in the house, the more depression is reported," the study said.

The report called poverty a "pathway to depression." It said that 75 percent of the U.S. poor are women and children.

Some groups of women are particularly susceptible, the report said. These include minority, elderly, chemically dependent, lesbian and professional women. It said these "need special attention and support."

Although depression now readily yields to treatment in 80 to 90 percent of all patients, most women with the ailment go untreated.—*The Elkhart Truth,* Dec. 5, 1990.

**by Anne Chamberlain**

# Depression

June 13, 1988:

"God, I feel awful. I feel depressed, and so afraid of falling apart, or of never feeling better; of everyone leaving me because I'm so miserable. Didn't sleep well at all last night...only 2 1/2 hours. I feel so wiped out! I feel like crying a lot. My usual coping techniques of working, of keeping busy, just aren't working. It takes so much energy to be sociable with people—that I feel completely drained by work, by friends. I have no energy for sex. Even flirting has lost its appeal. I've lost the five pounds I gained in May in five days. I have no appetite. I feel like I have a constant lump in my throat. I don't even have the energy to think about suicide. I feel like dying."

I wish that I could credit the above journal entry as fiction, the word of a friend from church, or a combination of the many stories that I have heard in my counseling practice. But I can't. They are my words, written at the beginning of my own personal plunge into the depths of despair and depression.

Everyone experiences the "blues," feeling down and discouraged from time to time, but when the feeling of depression is combined with several other symptoms and persists for a period of two weeks or longer, or is the predominating mood for a period of a year or more, then a person is suffering from a clinical depression. In addition to a depressed mood, persons with a clinical depression may experience a markedly decreased interest or pleasure in usual activities, a significant weight or appetite change, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or excessive guilt, a diminished ability to concentrate or think, and recurrent suicidal thoughts or suicide attempts.

- **Schizophrenia affects approximately one person in a hundred. The disease affects men and women about equally. Its onset is usually in the late teens or early twenties. People suffering from schizophrenia usually have several of the following symptoms:**
  - **disconnected and confusing language.**
  - **poor reasoning, memory, and judgement.**
  - **eating and sleeping disorders.**
  - **hallucinations.**
  - **delusions.**
  - **deterioration of personal appearance and hygiene.**
  - **loss of motiviation.**
  - **poor concentration.**
  - **withdrawal.**

**Mental illness is an illness, not a punishment. It is treatable.—*Chronic Mental Illness: A Congregational Challenge.***

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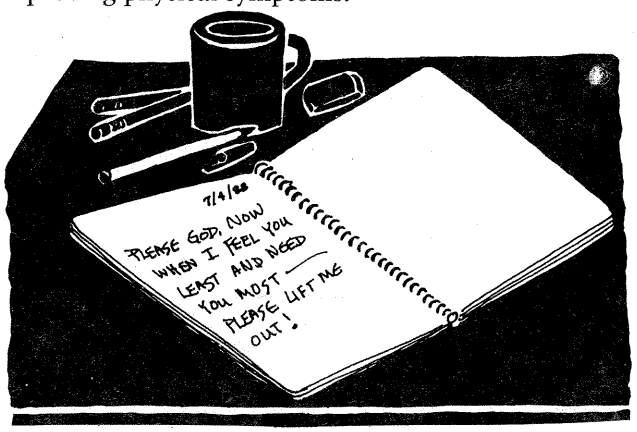
Psychological and/or biological factors are believed to play a part in depression. Psychological factors most often involve loss (of a loved one, or a relationship, of a job or health), or illogical and negative statements about self, current situations and the future, or learned helplessness. Psychotherapy is helpful in treating impaired social functioning, depressed mood, lack of motivation and suicidal thoughts. Biological therapies such as antidepressant medications are helpful for improving physical symptoms.




Depression is no stranger to me. I have experienced if off and on for many years. I can recall being depressed at age three, when I was the victim of a sexual molestation. I was depressed at age ten when my 18-year-old sister attempted suicide. I had other periods of depression throughout my adolescence and young adulthood, but I always managed to "tough them out," to get through the pain and on with my life.

My father died when I was 29, and I hit a mid-life crisis—wondering who I was besides a mommy and a wife and a daughter. This was a time of loss, not only of my father but also of my beliefs about myself. I entered counseling at that time and over a period of two years was able to begin to heal some of the painful experiences that I had as a child and the current losses I was feeling. I believed that I had fought the final battle with depression.

It is estimated that 15 percent of Americans will experience depression at some time in their lives. Women are twice as likely as men to become depressed. Fifty percent of those having a major depressive episode will fully recover and not experience another major depression. Four percent will experience recurrent depressions with long periods in between. Ten percent will be chronically depressed.

When I went into a major depression in 1988, I had never felt so terrible in my life. I felt like I had cancer of the soul. I was in counseling, and began taking antidepressants. After three months of feeling worse and worse, and after trying three different medications, I was at the point that I had to lie down after doing any simple task. I had lost twenty pounds on my 5'1", 120 pound frame, and hadn't slept for more than three to four hours a night in all that time. My therapist and I both agreed it was time for me to enter a psychiatric hospital. I was at the point that I couldn't go on, and would have either tried suicide or just given up living without the safety and healing of the hospital.

Because of my work as a therapist I chose to go out of town to the hospital. I didn't want any but my closest family members and friends to know. I was ashamed, and even more so as my children expressed their embarrassment that their Mom was in "the looney bin."

The most important lesson that I learned in the hospital was how to be needy. As a Christian, a mom, a wife, a friend, a therapist, I was used to meeting other's needs and not mine. I felt sinful and weak to need help from others. I had closed off my own pain from almost everyone, and finally broke under the load.

Getting help—in the form of support from family and friends, in the form of therapy, in the form of medication, in the form of the hospital—was an incredible risk for me. It was also a risk worth taking. After 38 days in the hospital, much hard work in therapy, and an effective medication, I was finally able to tell my story, to let my community see my needs.

As a Christian, depression challenged my relationship with God. The depressed person feels withdrawn and disconnected from others, including God. A journal entry from 7/4/88 expressed the need for God and the feeling of distance: "PLEASE GOD, NOW WHEN I FEEL YOU LEAST AND NEED YOU MOST—PLEASE LIFT ME OUT!"Worship became almost unbearable. I felt so guilty and angry when people shared stories of God being with them, of joy in the Lord, of answered prayer. What had I done to deserve this? Why didn't God take this away?

Depression began the process of letting God see me as I really am—needy, angry, afraid, alone. I realized that I was in good company—that spiritual giants have also suffered from depression (consider Elijah after Mount

**Twelve million children, infants through 18 years old, can and do suffer diagnosable mental disorders such as depression, attention deficit disorder and pervasive developmental disorders.—*Who Are the Mentally Ill?***

**Due to deinstitutionalization, up to 80 percent of chronically mentally ill people are now dependent for their daily care on family members or friends, or are struggling along to maintain their day-to-day existence.—*Chronic Mental Illness: A Congregational Challenge.***

Carmel, Naomi after her sons died, and Jesus in the hours before the crucifixion). I learned that "Emmanuel—God with us" means just that: that God is with us whatever we feel. I learned that there were no instant miracles, no formulas for prayer or devotions to get rid of the depression, but rather, that God was with me in it—understanding it, feeling it too. I learned that Jesus is a "wounded healer," and I could be one also.

Caring for a depressed person can be difficult. It hurts to see someone in so much pain. I found it helped me most when people simply listened to me and let me know that they saw how bad I felt. Simple answers like "it's probably from the hole in the ozone layer" or "if you just praise the Lord more, you'll have joy in your life" made me feel even more guilty and powerless. It is better to offer support—to go for a walk together, to take on the person's prayer list for a month, to be available to talk at odd hours. Let the person know that you care, even though they may seem withdrawn. Depression is a mental illness that can be fatal, so check out statements and actions that may indicate suicidal thoughts. Talking about suicide won't plant ideas in the depressed person's mind. Rather, it will be a relief to be able to talk frankly about the extent of pain the person feels.

I believe that I will always have a tendency to get depressed. I may even suffer from another major depression, but I have some tools that can make it easier the next time. I know what the triggers are for me, and the warning signals, so I am able to intervene more quickly and more effectively. I have the experience of having survived intact, so I know that I can survive another episode. I know that it will end.

A year after the major depression, I was driving in my car after having lunch with a friend. It was a crisp fall day, and I was looking forward to doing some work in my yard. I suddenly realized that the world was full of wonderful colors, scents, textures. In the depression, the world had looked gray. I felt strange—happy and content—for the first time in ages. I have added the word "hope" to my vocabulary. I can get better.

**Anne F. Chamberlain is a certified clinical mental health counselor at Harrisburg Area Psychological Services. She and her husband and two sons attend the Harrisburg Brethren in Christ Church (Pa.) where she chairs the church board. This article is reprinted from *Shalom!*, the quarterly publication of the Board for Brotherhood Concerns of the Brethren in Christ Church.**

# Resources

**Depression**

Gold, Mark, M.D. and Morris, Lois B. *The Good News About Depression: Cures and Treatments in the New Age of Psychiatry,* Random House, New York, 1987.

Griest, John & Jefferson, James. *Depression and Its Treatment: Help for the Nation's No. 1 Mental Problem,* American Psychiatric Press, Washington, D.C., 1984.

Papolos, D., and Papolos, Janice. *Overcoming Depression,* Harper & Row, New York, 1987.

**Schizophrenia**

Hyde, Alexander P. Living With Schizophrenia: A Guide for Patients and Their Families, Contemporary Books, Chicago, 1982.

Torrey, E. Fuller. Surviving Schizophrenia: A Family Manual, Harper & Row, New York, 1988.

Walsh, Maryellen. Schizophrenia: Straight Talk for Families and Friends, Warner Books, New York, 1986.

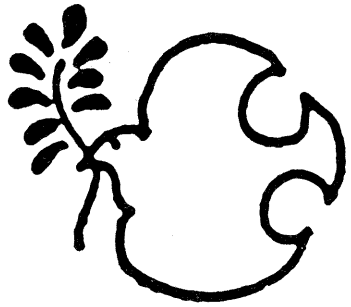
- **The following organizations/programs offer a variety of educational materials:**

- **Canadian Mental Health Association**
  **2160 Yonge Street**
  **Toronto, Ontario M4S 2Z3**

- **MCC Canada**
  **Mental Health Programs**
  **134 Plaza Drive**
  **Winnipeg, Manitobo R3T 5K9**

- **National Alliance for the Mentally Ill**
  **1901 N. Fort Myer Drive, Suite 500**
  **Arlington, VA 22209**

- **Pathways to Promise**
  **5400 Arsenal Street**
  **St. Louis, MO 63139**



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**Videotapes**


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*Independence Center (20 mins.), and Places for People* (20 mins.), George Warren Brown School of Social Work, Washington University, St. Louis, MO 63130, 1985. 24 mins, 1/2 in., VHS.

*Roads To Recovery:* MHAC, 265 Fort Rd., St. Paul, MN 55102, 1987. 29 mins., 1/2 in., VHS.

*When The Music Stops.* NAMI, 2101 Wilson Blvd., Suite 302, Arlington, VA, 1987. 20 mins., 1/2 in., VHS.


—Resources listed in *Who Are the Mentally Ill?*

**Women in Ministry:**

- ***April Yamasaki*** **has been appointed writer-in-residence and an instructor in English at Columbia Bible College, Clearbrook, B.C.**
- ***Vera Isaak*****, Springstein (Man.) Church, has begun as director of SELFHELP Crafts Canada.**
- ***Jayne Byler*** **was ordained as pastor of Summit Mennonite Church, Barberton, Ohio, in Sept. She was licensed in 1988.**
- **Paul and *Nora Molter* became pastors of Carbondale (Pa.) Agape Fellowship in October.**
- ***Kathryn Rempel*** **was ordained as co-pastor of University Mennonite Church, State College, Pa., in October. She serves alongside her husband, Ed.**
- **Wayne and *Lavonne Bohn* became pastoral team members at Lower Deer Creek Mennonite Church, Kalona, Iowa, recently. Lavonne is women's ministry counselor.**
- **In Sept. *Linda Schmidt* of Littlestown, Pa. was ordained and installed as pastor of Faith United Church of Christ, Littlestown Pa. In October she began serving as coordinator for the Interfaith Center for Peace and Justice in Gettysburg, Pa.**

# Letters

After reading the *Report* issue on co-dependency (No. 91) my husband decided to use it as a resource for a workshop he is doing for people working with drug-addicts. Unfortunately, it inadvertently got put out with the papers to be recycled. I would appreciate it if you could send me another copy of that issue.

I enjoy reading every issue of *Report* and encourage you to keep up the fine work.
*—Martha Magee, Almere, the Netherlands*

Please add the name of my friend to your mailing. She is active in organizing Mennonite retreats for women. Enclosed is a check.

Your newsletter is always stimulating to me. Thank you very much for your work well done. This summer I was in Winnipeg at the Mennonite World Conference. I was surprised that I didn't find workshops on women's concerns. I was disappointed.
*—Dora Geiser, Neuwied, Germany*

I regularly read *Report* with great interest. I admire how you deal with sensitive personal and social issues that are so pertinent to women's lives. A women's discipleship group in our congregation is considering using Report for discussion in the group. Thank you for your good work.
*—Kathrine Rempel, State College, Pa.*

*Report* continues to be an important source of information and encouragement on very important issues affecting women and ultimately those around us. Keep up the good work.
*—Jean A. Hilborn, Acton, Ontario.*

I have found *Report* beneficial personally and in my work as a psychiatric nurse. Thank you for your part in putting it together.

I need two more copies of the issue on co-dependency (No. 91). I misplaced mine and want to use one at work.
*—Ginny Schwartzentruber, Goshen, Ind.*

Much of my awareness concerning peace and justice has come from Mennonite literature. Thank you for the wonderful *Report* issue on the environment (No. 92). I am making many small changes in my lifestyle, one of which is to consciously remove all one-time use items from my home.

Seeing the need for my community to have reusable canvas bags available, I began a small business selling them. Tree Saver canvas bags are made at The Sheltered Workshop which employs handicapped adults. The bags are available retail and wholesale. Many churches are using them as fund-raising projects. Please write to Eleanor Elliott, Tree Saver Co., Rt. 4, Box 24, Waynesboro, VA 22980 for more information.
*—Eleanor Elliott, Waynesboro, Va.*

We are a group of English-speaking women who meet together each year for prayer and praise, women's concerns, spiritual nourishment, fellowship and fun. Our conference this year will include some concerns for the environment and what we here in Japan can do about our wasteful lifestyles.

One of our participants sent the *Report* issue on the environment (No. 92) and we would like to quote from it in our program. We will give you due credit.

Thanks so much.
*—Betty S. Swain, Tokyo, Japan*

# News and Verbs

"Shedding Light on Darkness", a conference on domestic violence and sexual abuse was held at Upland (Calif.) Brethren in Christ Church on Nov. 2-3, 1990. An estimated 200 participants from 19 states and from five provinces attended the gathering, planned by the MCC Domestic Violence Task Force, MCC Committee on Women's Concerns and West Coast MCC.

Keynote speaker Ruth Krall, director of peace studies for Goshen (Ind.) College, established the scope of the problem in society in her opening address. Her own study of the problems of rape, battering and child sexual abuse has revealed that these problems also exist within the church.

**I tell you whenever you refused to help one of these least important ones, you refused to help me. *Matt. 25: 45.***

**Illustrations in this issue were drawn by Teresa Pankratz of Chicago. Please do no reproduce without permission.**

"Stories I now know of abusive fathers, uncles, brothers, choir directors, pastors, show me that Mennonites and Brethren in Christ churches are not immune," said Krall.

The keynote addresses as well as many of the 18 workshops offered dealt either directly or indirectly with the church's role and responsibility to offer help to abused persons.

Krall outlined several ways the church can express its concern, including: listening to and believing people's stories, learning about the issue and identifying abuse as sin, clearly defining sexually responsible behavior for church leaders, and requiring restitution and accountability from perpetrators of abuse.

One outgrowth of the conference was the establishment of a Network of Adult Survivors of Abuse. Persons participating in the network will receive a confidential listing of names, addresses, and phone numbers of all the people who have responded. The network is only open to people who have experienced or are experiencing abuse. Those wishing to join the network should write to: Network of Adult Survivors, MCC Domestic Violence Task Force, P.O. Box 1292, Winkler, MB R6W 4B3.

In Queens, New York, members of Saint John's University sports teams, **fraternities and sororities have been ordered to attend seminars on sexual abuse**, sexual ethics, drugs and alcohol, and self-esteem. All male students at the Catholic University are receiving a brochure titled *No Means No*. Women are receiving a brochure entitled *What Every Woman Should Know About Sexual Abuse.*

*WOMEN'S CONCERNS REPORT* is published bimonthly by the MCC Committee on Women's Concerns. The committee, formed in 1973, believes that Jesus Christ teaches equality of all persons. By sharing information and ideas, the committee strives to promote new relationships and corresponding supporting structures in which men and women can grow toward wholeness and mutuality. Articles and views presented in *REPORT* do not necessarily reflect official positions of the Committee on Women's Concerns.

*WOMEN'S CONCERNS REPORT* edited by Christine Wenger Nofsinger. Layout by Shirley Stauffer Redekop. Correspondence and address changes should be sent to Chris Nofsinger, Editor, MCC, PO Box 500, Akron, PA 17501-0500.

U.S. residents may send subscriptions to the above address. Canadian residents may send subscriptions to MCC Canada, 50 Kent Avenue, Kitchener, ON N2G 3R1. A donation of $10.00 per year per subscription is suggested.

*This newsletter is printed on recycled paper.*

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